 EXH. 16

**Spine and Orthopedic Center of New Jersey, LLC**

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**DAVID B. BASCH, MD, FAAOS**
Fellow-American Academy of Orthopedic Surgeons
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July 11, 2007

MAHONEY & BAKER, P.C.
Attorneys At Law
2740 Route 10 West
Morris Plains, New Jersey 07950

**GOERNER, PERRY**
**D.O.A.** April 27, 2007

Dear Mr. Mahoney:

Enclosed is my narrative report regarding my care and treatment of Perry Goerner, related to the MVA of April 27, 2006. Mr. Goerner was riding his motorcycle and came to a complete stop before an intersection when he was rear-ended at a high rate of speed. The patient was ejected from his bike was thrown forward and hit a van head first with his full-faced helmet. He lost consciousness. Police and ambulance arrived on the scene. The patient can recall as he climbed out from underneath the van he was thrown into that bystanders remarked, "He's alive!". The patient was taken via ambulance to Chilton Memorial Hospital. He was evaluated by emergency room staff and x-rays of his cervical and lumbar spine were performed. The patient was discharged home the same day with medications including Tylenol with codeine. He later followed up with his primary care physician and was placed in physical therapy for several weeks. The patient then obtained an MRI of his lumbar spine which revealed internal disc disruption and disc herniation noted at L3-4 with a disc bulge at L4-5 with an annular tear present as well as hypertrophic changes noted at L5-S1.

Since that time he has been having problems regarding his back, neck, shoulders and has been left with a cognitive deficit as well. He is not doing well at this time as he is still having significant complaints of pain in his lower back, pain that radiates into both legs left greater than right. He states that he recently saw a neurologist because of memory loss. He is having significant complaints of weakness in his right leg. He

states that the insurance company sent him to physicians including Dr. Rubinfeld for an Independent Medical Evaluation. He states that the evaluation by Dr. Rubinfeld was very cursory. The patient states that he was made to walk back and forth, bend over and to the side and lift his arms over his head. The patient states that he also brought his MRI films in with him for the evaluation as instructed but Dr. Rubinfeld did not even look at the films. When asked about the films, Dr. Rubinfeld replied, "I have the reports". The patient feels that the pain in his neck, back, shoulders is interfering with his activities on a daily basis and that he is leading a very decreased quality of life because of his current symptoms. He now comes in for further evaluation.

Physical Examination: The patient is ambulating with an antalgic gait secondary to lower back pain. He has mild kyphotic posture and difficulty standing erect. He is able to rise on the heels and toes but cannot sustain these positions secondary to pain. He is very slow getting up from a seated position.

Examination of the cervical spine shows tenderness directly over the posterior cervical muscles, the lower spinous processes, and the trapezius muscles bilaterally and in the interscapular region. Range of motion of the cervical spine is mildly stiff and restricted. Forward flexion and extension are to 45 degrees, normal is 60 in each direction. Side bending and rotation are to 45 degrees with pain at the ends of motion, normal is 45. There is weakness of the cervical muscles on isometric testing. There is considerable tenderness over the occiput. There are multiple trigger points noted throughout the trapezius muscles bilaterally consistent with areas of chronic muscular spasm and fibrous adhesions. Spurling test is positive bilaterally. Neurological examination shows that the patient has complaints of radicular pain in the distribution of C4-5 and / or C5-6 bilateral. His sensation is intact and motor-testing shows preserved strength in both upper extremities from C5 to T1.

Examination of the shoulders shows tenderness over the anterolateral aspect of both shoulders. There is also moderate stiffness of the left shoulder. His forward flexion is to 160 degrees, normal is 180. His abduction is to 100 degrees with pain, normal is 120. He also has stiffness when placing the left shoulder behind his back. There are positive impingement signs noted bilaterally. Range of motion of the right shoulder is near full but he has pain at the ends of motion. There is positive impingement sign and positive O'Brien test on the left side. There is also tenderness over the right bicipital groove. There is weakness of the rotator cuff on the left with grade 4/5 strength when compared to the opposite side.

Examination of the left hand shows a positive grind test at the first digit. There is tenderness over the MCP joint. There are negative Tinel and Phalen signs. There is mild decreased grip strength on the left when compared to the opposite side.

Examination of the lumbar spine shows tenderness directly across the lumbosacral junction, the paralumbar muscles, and both sciatic notches. Range of motion of the lumbar spine moderately stiff and restricted with forward flexion to 50 degrees, normal is 90. Extension is to 15 degrees, normal is 40. Of note, there is a very positive spinal Gowers sign when the patient rises from a flexed position. Straight leg raising is positive on the left at 70 degrees with a positive Lasègue maneuver, and negative on the right at 90 degrees. There is tenderness noted over the thoracolumbar junction as well. Multiple trigger points are noted throughout the paralumbar muscles consistent with areas of chronic muscular spasm and fibrous adhesions. The remainder of his neurological exam is intact except for his radicular complaints.

Diagnoses:

1. Chronic lumbar strain with internal disc disruption and disc herniation noted at L3-4 with disc bulge present at L4-5 and internal disc disruption and facet joint arthropathy at L5-S1. Rule out bilateral radiculopathy symptomatic.
2. Chronic cervical strain (whiplash injury). Rule out internal disc disruption or herniation.
3. Bilateral shoulder strains right greater than left. Rule out rotator cuff tendonitis or tear.
4. Strain of the left first digit. Rule out CMC osteoarthritis with exacerbation.
5. Cognitive deficits secondary to MVA.

Discussion: At this time the findings have been discussed with the patient. I discussed the diagnoses with Mr. Goerner in detail today. It remains my medical opinion that the patient's current symptoms, injuries and diagnoses as noted above are directly causally related to the motor vehicle accident of April 26, 2006. The patient has had a long course of conservative care with only minimal improvement. I also discussed other treatment options with him including pain management and surgical intervention. I will also have the patient obtain further evaluation with an MRI of the cervical spine to rule out herniated disc and MRI of the right shoulder to rule out impingement syndrome, rotator cuff tear or tendonitis. He will continue with his physical therapy for now, three times per week for four weeks for both shoulders, neck and lower back. I also renewed multiple medications including anti-inflammatory medication Naprelan and muscle relaxant Flexeril. The patient remains completely disabled and is not able to return to work in any capacity. I have also discussed other treatment options if his pain persists or worsens including pain management with a series of Lumber and or Cervical epidural or selective nerve root steroid injections as well as surgical consideration. This patient would require decompressive laminectomy and or spinal fusion surgery. I have discussed the surgery with the patient in detail today. I have discussed the risks and benefits of surgery as well. The risk of spinal surgery include but are not limited to

bleeding, infection, continued pain, swelling, stiffness, numbness, nerve damage, spinal leak, failure of the bone to heal, and possible need for further surgery. The patient states he understands and would like to think about the surgery. He is going to return for follow-up in one month for further review, to see how he is progressing and continued discussion regarding treatment options.

Of note, at this time I also had opportunity to review multiple medical records including reports from Skyview Orthopedic Associates as well as from his neurologist, Neurospecialists of Morris Sussex. I also reviewed MRI report from Roxbury Imaging Center. I reviewed a New Jersey Police crash investigation report from date of injury April 27, 2006. I reviewed the emergency room records from St. Clare's Hospital. I also reviewed multiple physical therapy records from Sparta Orthopedic and Sports as well as prescription blanks for physical therapy. I also discussed other treatment options with the patient if his pain persists or worsens including referral to pain management for a series of cervical and / or lumbar trigger point or epidural steroid injections as well as surgical considerations. Of note, at this time if the patient's Independent Medical Evaluations result in any denial of treatment, then please consider this note as "additional documentation" and as an appeal letter as well. I would also like the opportunity to review Dr. Rubinfeld's. It does remain my medical opinion that the patient's current symptoms, injuries and diagnoses as noted above are directly causally related to the motor vehicle accident that occurred on April 27, 2006, and that he does require further treatment as noted above which is medically necessary. The rationale for my opinions is supported by standards of orthopedic care and professionalism, New Jersey PIP Care Paths, and Orthopedic Knowledge Update Spine 3.

Of note, even with further treatment, it is my medical opinion that the patient's current symptoms, injuries and diagnosis noted above are permanent in nature. It is also my medical opinion that the patient's overall prognosis is very guarded since he has been left with significant residual sequelae from the accident in question, interference with his activities of daily living, and requires continued and ongoing treatment in the future including surgery as noted above. All my medical opinions as stated are within a reasonable degree of medical certainty.

Sincerely,

David B. Basch, MD, FAAOS

State of New Jersey
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NEURO-SPECIALISTS OF MORRIS-SUSSEX, P.A.
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PATIENT Perry Goerner D.O.B.
ADDRESS DATE 9-1907

Rx

Perry is still being followed by Dr. Eric Englestein in our office. Any Questions please Call. Thank You.

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PATIENT Perry Goerner D.O.B.
ADDRESS DATE 9/19/07

Rx

Patient is under my care. No work to be performed until further notice.

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973-898-1000
Attorney for Plaintiff

| | |
|---|---|
| PERRY GOERNER,<br><br>Plaintiff,<br><br>-v-<br><br>ARTHUR FREUND,<br><br>Defendant. | SUPERIOR COURT OF NEW JERSEY<br>LAW DIVISION - ESSEX COUNTY<br>DOCKET NO.:<br><br>Civil Action<br><br>CERTIFICATION OF TREATING PHYSICIAN |

I, David B. Basch, M.D., do hereby certify as follows:

1. I am a licensed orthopedist of the State of New Jersey and I examined/treated plaintiff, Perry Goerner, for injuries he sustained in an accident that occurred on April 27, 2006.

2. Attached hereto is a true and correct copy of my narrative report regarding my treatment of plaintiff which sets forth the details of his treatment and my diagnosis of his condition.

3. In my opinion within a reasonable degree of medical probability, my patient has sustained an injury which has:

(Choose all appropriate):

_____ resulted in death.

_____ resulted in dismemberment

_____ resulted in significant disfigurement or significant scarring

_____ caused a displaced fracture.

__X__ is permanent and has not healed to function normally.

4. I certify that the foregoing statements are true to the best of my knowledge, information and belief. I am aware that if any of the foregoing statements made by me are wilfully false, I am subject to punishment.

Dated: 6/1/07

David B. Basch, M.D.